Conclusions: This largest study of IFAA demonstrates that: 1. Acute complications did not occur in aneurysms smaller than 3.5cm; repair criteria for asymptomatic FAA should be changed to >3.5 cm 2. The presence of chronic FAA thrombus should reduce the threshold for elective repair. 3. Criteria for symptomatic FAA repair should remain unchanged.

Author Disclosures: C. J. Abularrage: Nothing to disclose; **S. S. Ahn**: Nothing to disclose; **J. L. Ballard**: Nothing to disclose; **P. Flanigan**: Nothing to disclose; **M. P. Harlander-Locke**: Nothing to disclose; **N. Hedayati**: Nothing to disclose; **M. D. Humphries**: Nothing to disclose; **G. J. Landry**: Nothing to disclose; **P. F. Lawrence**: Nothing to disclose; **B. Mendes**: Nothing to disclose; **M. Mueller**: Nothing to disclose; **G. S. Oderich**: Nothing to disclose; **W. C. Pevec**: Nothing to disclose

VS6.

Video Presentation

Trans-Catheter Aortic Valve Replacement Access, Complications, and Bailouts

Manish Mehta[1], Augustin J. Delago[3], Edward V. Bennett[2], Lewis W. Britton[2], Mohammed C. El-Hajjar[2], R. Clement Darling[1], Philip S. Paty[1], Yaron Sternbach[1]. [1]The Vascular Group, The Institute for Vascular Health and Disease, Albany Medical College, The Center for Vascular Awareness Inc, Albany, NY; [2]Albany Medical Center Hospital, Albany Medical College, Albany, NY; [3]Capital Cardiology Associates, Albany Medical Center Hospital, Albany Medical College, Albany, NY

Background: Transcatheter aortic valve replacement (TAVR) has revolutionized treatments for patients with severe symptomatic aortic valve stenosis. In 2011 FDA approved TAVR for surgically inoperable patients, and in 2012 for surgical high risk patients. Currently randomized trials are underway evaluating the efficacy of TAVR for surgical low risk patients. Similar to TEVAR, TAVR requires navigation of 22-25Fr sheaths and catheters across the aortoiliac segments and expose patients to the risks of arterial injury, bleeding, and stroke. As vascular surgeons we have participated in nearly 100 TAVR procedures, and can attest to the importance of vascular surgeons involvement in not only limiting patient risks, but also in expanding the indications for patients with critical aortic stenosis and no other treatment options, as well as in managing bailouts following complications of these procedures.

Technical Description: This video presentation will focus on the implications of appropriate access during TAVR. Tips and tricks to the bailout procedures needed during misplaced aortic valves that require retrieval, as well as diagnosis and treatments for arterial injury during trans-femoral and trans-apical TAVR.

Author Disclosures: E. V. Bennett: Nothing to disclose; **L. W. Britton**: Nothing to disclose; **R. Darling**: Nothing to disclose; **A. J. Delago**: Nothing to disclose; **M. C. El-Hajjar**: Nothing to disclose; **M. Mehta**: Abbott Vascular, Inc, Cordis Corporation, Terumo Cardiovascular Systems Corporation, Trivascular, Inc, W.L. Gore & Associates, Inc, Lomard Medical Technologies Inc, Bolton Medical, Inc, Medtronic Inc, Aptus Endosystems Inc, ev3 Endovascular, Inc, Maquet Cardiovascular Harvest Technologies Corp, Research GrantsEV3 ENDOVASCULAR, INC, W.L. GORE & ASSOCIATES, INC, CORDIS CORPORATION, TRIVASCULAR, INC, Consulting fees or other remuneration (payment); **P. S. Paty**: Nothing to disclose; **Y. Sternbach**: Medtronic, Inc, Speaker's bureau.

SS25.

Management of Acute Limb Ischemia in the Pediatric Population

Ahmed Kayssi[1], Furqan Shaikh[2], Graham Roche-Nagle[1], Barry Rubin[1], Leonardo R. Brandao[2], Suzan A. Williams[2]. [1]Division of Vascular Surgery, University Health Network, University of Toronto, Toronto, Ontario, Canada; [2]Division of Haematology/Oncology, The Hospital for Sick Children, University of Toronto, Toronto, Ontario, Canada

Objectives: Acute limb ischemia (ALI) in pediatric patients is rare but may lead to limb loss and life-long complications. The aim of this study was to review the experience of a Canadian tertiary pediatric center with the medical and operative management of ALI.

Methods: The charts of in-patients diagnosed with acute upper or lower limb ischemia between 1999-2012 were reviewed. Patient demographics, arterial clot site and etiology, intervention, anticoagulation type and duration, and short and long-term complications were analyzed.

Results: 136 patients presented with signs of limb ischemia (46% female, 34% younger than 30 days, 51% between 1-12 months, and 15% between 1-18 years). 95% involved the lower limbs. 85% of arterial clots were totally occlusive. 92% were due to vessel catheterization, 5% were idiopathic, and 2% were due to hereditary hypercoagulable states. 96% were managed nonoperatively. Patients were treated with a combination of thrombolysis, unfractionated or low molecular-weight heparin, aspirin and/or warfarin (duration, 1 day-13 years). All patients were followed postdischarge at our institution or at their referring hospital (average, 3.5 years). 13% had complications related to ALI or anticoagulation (limb length or thigh circumference discrepancy, or intracranial hemorrhage). 25 patients died of unrelated causes (sepsis, multi-organ dysfunction, or cardiac failure).

Conclusions: In contrast with adults, ALI in children can generally be managed nonoperatively with anticoagulation, likely because of their greater ability to develop arterial collaterals. Long-term follow-up by a multidisciplinary team of pediatric and surgical specialists and allied health professionals is integral to achieving a successful outcome.

Author Disclosures: L. R. Brandao: Nothing to disclose; **A. Kayssi**: Nothing to disclose; **G. Roche-Nagle**: Nothing to disclose; **B. Rubin**: Nothing to disclose; **F. Shaikh**: Nothing to disclose; **S. A. Williams**: Nothing to disclose.

SS27.

The Positive Effect of Reentry Device With Intravascular Ultrasound on Technical Success, Safety and Patency of Subintimal Angioplasty of Chronic Total Occlusion in Iliac Arteries